

ILLINOIS DEPARTMENT OF CORRECTIONS

Hill Correctional Center

Offender Outpatient Progress Notes

Offender Information:

Shelds

Last Name

Ernest

First Name

MI

ID#: 130616

Date/Time	Subjective, Objective, Assessment	Plans
10/17/08	New doc ten is now T. Ken.	
1:45P	P.O + SC notified of chg. of add. to add. St	
1/20/08	RN note	
6/10/08	Health Status Completed for med furlough today	5. Habenink
6/21/08	RN Note	
7:45AM	I/M left on med furlough	P Brown
7:05AM	Notified that returned from med. furlough	P Brown
8:00AM	Informed by Ray Henry SA - that P-T was refused I/M thought that he was having surgery for repair of per. tear. To follow up w/ Staff MD	P Brown
7/26/08	MD visit	
3:40P	wt - 193.6 BP - 108/78	?
7/26/08	P - 78 R - 18 T - 97.8	① Edphic (Med) Mr. Sheld that it is important
②	5' 38 years old Mr. Sheld will ha -	that he get the Physical therapy as advised by M.D.
③	Doctor has no tender scutum of 116 lbs. informed patient that the will be due for	Physical therapy as advised by M.D.
	Continued - myotars	

ILLINOIS DEPARTMENT OF CORRECTIONS

Hill Correctional Center

Offender Outpatient Progress Notes

Offender Information:

Shields

Last Name

Eacroot

First Name

ID# B166161

MI

Date/Time	Subjective, Objective, Assessment	Plans
10/26/08 3:45	Caret. MD. WGN 3rd visit for Physical. Re- Tierfy patient reported saying that he is and will Refuse for Physical therapy, and no work saying. CJ - Keltz, OZS -CRS Nend -CJ A. Nant -Adeline Big -Ext. LIZ Nee -A1 ① C. Pectoral Tendon Rupture	P ② Nursing Staff if Mr. Shields Refuse Refuse for Physical Therapy; please have him sign the Refusal form and submit to me for review Please you
3:08	LPN NOTE	Motivations Falsify
6/15/08	I/IN DECLARED HUNGER STRIKE AT APPROX 0330 A U/S TAKEN P100% 90 P60 R16 & 90 AT THIS TIME	Refusal not found

May. 25. 2010 1:55PM

SMU

ILLINOIS DEPARTMENT OF CORRECTIONS

No. 2943

P. 26-28-08

Offender Health Status Transfer Summary

Transferring Facility:

1471 CC

Center

Offender Information:

Shelds

Last Name

Eason

First Name

MI

ID# B66161

Date: 10/27/08

Time: 6:24:5

 a.m. p.m.Transfer Screening (completed by transferring facility health care staff): HIV Test & Counseling Offered (only transfers to ATC, parole, release or discharge)

Allergies: NSA

Food Handler Approved: b/c

Current / Acute Conditions / Problems: (D) shoulder - pectoral tender n/p tenu

Chronic Conditions / Problems: G

Current Medications (name, dosage, frequency, and duration):

Acute Short-term: Motrin 800mg POTID X 7 days

Chronic Long-term: G

Chronic Psychotropic: G

Current Treatments: G

Therapeutic Diet: G

Follow-Up Care: R&C

Dental Clinics: G

Specialty Referrals: Physical Therapy Cottage Rehab.

Significant Medical History: GSW of D foot and ankle, depression

Physical Disabilities / Limitations: G

Assistive Devices / Prosthetics: G

Mental Health Issues: Hx Suicide Attempt: Date: / / Hx Psych Med Hx MPC / STC Substance Abuse: Alcohol Drugs

Conover, RW

Print Name and Title

Conover, RW

10/27/08

Date

Reception Screening (completed by receiving facility health care staff):

Facility: Date: / / Time: a.m. p.m.
Objective: Assessment:

Current Complaint:

Current Medications/Treatment:

Plan/Disposition:

- Health Information Given Emergency Referral: _____
 Sick Call: Urgent / Routine Therapeutic Diet Special Housing Chronic Clinics
 Medication Evaluation Work / Program Limitation Specialty Referrals Other (specify): _____
 Work / Program Limitation Specialty Referrals Other (specify): _____
 Infirmary Placement: _____
 HIV Test & Counseling Offered (only transfers from R&C)
 Other (specify): _____

Printed Name and Title

Signature

/ /

Date

For Adult Transition Center transfers only:

I understand that medical and dental care are my responsibility while I am housed in a transition center. I also understand that if I am in need of health care and I cannot afford to pay for it, I may be transferred back into a facility within the Department that can provide my medical, mental health, or dental needs.

Offender's Signature

Date

Time

 a.m. p.m.

Distribution: Offender's Medical Record; Transferring Facility; Recieving Facility

DOC 0090 (Rev. 1/2008)

ILLINOIS DEPARTMENT OF CORRECTIONS
Medical Special Services Referral and Report

DOC C
(Facility)

Offender's Name: Shelby Ernest

ID# B66661

Reason for Referral:

- Consult Non-Formulary Medications Medical Equipment
 Evaluation Management
 Procedure/service (specify) _____
 Other (specify) _____

Urgent: Yes No

Referred to: Cottrell Rehab & P.T.

Rationale for Referral: 3rd Visit for Physical Therapy

Print Referring Practitioner's Name:

Referring Practitioner's Signature

Date:

Report of Referral (Use Reverse Side, if necessary)

Findings: A continues to demonstrate obvious injury to the right arm & shoulder. There is significant edema and elicited tenderness/tightness in the right trapezius muscle belly.

Assessment: The right shoulder is unchanged compared to the initial evaluation. ROM is not decreased compared to the initial evaluation. To the pt continuing to do significant passive shoulder strength testing was deferred today as it's just limited

Recommendations/Plans: The pt has not benefitted from PT and has been unable to progress toward pain relief and ROM goals. Due to at this time a further course of action re: pt's injury per the MD. The pt would benefit from surgery orthopedics MD (if this hasn't been done already).

Print Practitioner's Name: Jason Granbone

Practitioner's Signature: Jason Granbone, PT

Date: 10/28/08

Facility Medical Director Use Only

I have reviewed the recommendations and:

- Approve.
 Deny or revise as indicated on the Notification of Medical Service Referral Denial or Revision, DOC 0255.

Print Facility Medical Director's Name

Facility Medical Director's Signature

Date

ILLINOIS DEPARTMENT OF CORRECTIONS
Offender Outpatient Progress Notes

HILL

Center

Offender Information:

OR-37
Seq.

Shields

Ernest

Last Name

First Name

ID# B66161

M

TREATMENT PROTOCOL - MUSCLE PAIN/SPRAIN

Date/Time	Subjective, Objective, Assessment	Plans
11/19/88 2:45	S. What caused pain? Hx: Pectoral muscle tear (1) Pain duration: Constant. Location: (1) Pectoral Pain (1-10 most sever): 10/10 What precipitates pain? "When I lay down" Alleviates pain? Nothing	P. MD referral: (If any suspected fracture, difficulty walking, numbness, severe pain/swelling, deformity and/or fever). 1. \$2 copay implemented due to inmate's request for non-emergency medical services. meds: 800mg PO TID x 10 days NSAID: Motrin No MD referral: (check as applicable):
O.T : P 82 R 20 BP 110/88		1. Ibuprofen 200 mg 3 tabs p.o. QID PRN x 3 days. 2. Cold compresses x 48 hours; then warm moist packs PRN. 3. Elevate affected part. 4. Lay-in x 24 hours.
Appearance at rest: holds left neck		
Appearance with movement: full ROM, but pain exists		Patient teaching (check as applicable):
Swelling: Y () Ecchymosis: Y () Redness: Y ()		1. Medication usage. 2. Use of cold/hot application. 3. Avoid weight lifting, sports or strenuous activity until area has healed and is free of pain (approx. 2 wks).
Bruising: Y () Tenderness on touch: Y () Limited ROM: Y ()		4. Importance of body mechanics to avoid injury. 5. Instruction regarding safety measures if injury preventable. (warm-up exercises, etc.) 6. Return if symptoms fail to resolve within 3 days or if symptoms worsen.
Ankle Ottawa Rules		7. Complete Resident Injury Report form, if applicable.
Knee Ottawa Rules		
I/m c/o pain, numbness, but no sensation present upon palpation		

ILLINOIS DEPARTMENT OF CORRECTIONS.

Hill Correctional Center

Offender Outpatient Progress Notes

Offender Information:		
<u>Shields</u> Last Name	<u>Ernest</u> First Name	
	MI	ID# <u>B106161</u>

Date/Time	Subjective, Objective, Assessment	Plans
12-15-08 1:10p	ELP Note - NSC On NSC requesting to be taken off Medical hold. This time inmate did not want to be seen for NSC.	P- Refusal signed for refusing NSC @ RIC P.D. <i>Sign</i>
12/17/08 2:30pm	MD note This pt has been evaluated by out + mo. Surgeon has been recommended to DMH. He has had P/F to the extent that it will be safe for him & the carers. Status is in baseline. No further medical follow up planned.	P- D/c medical hold Riverside School for MS By Dr MP <i>No follow up</i>

ILLINOIS DEPARTMENT OF CORRECTIONS
Offender Health Status Transfer Summary

Transferring Facility:

Police Center

Offender Information:

<u>Shields</u>	<u>Earnest</u>	ID# <u>B660101</u>
Last Name	First Name	MI

Date: 1/12/09Time: 1700 a.m. p.m.Transfer Screening (completed by transferring facility health care staff): HIV Test & Counseling Offered (only transfers to ATC, parole, release or discharge)Allergies: NKA

Food Handler Approved:

2/28/08 YesCurrent / Acute Conditions / Problems: C

Chronic Conditions / Problems:

Current Medications (name, dosage, frequency, and duration):

Acute Short-term: SChronic Long-term: SChronic Psychotropic: S

Current Treatments:

Therapeutic Diet: RegularFollow-Up Care: RHC

Chronic Clinics:

Specialty Referrals:

Significant Medical History: h/o gsw D Foot/Ankle h/o depression - S meds

Physical Disabilities / Limitations:

Assistive Devices / Prosthetics:

 Glasses DenturesMental Health Issues: Hx Suicide Attempt Date: 1/1 Hx Psych Med Hx MPC / STC Substance Abuse: Alcohol DrugsR & C Use Only: LAB EKG CXR Dental MEDS MH Other: Packet CompleteKethren

Print Name and Title

Kethren

Signature

1/12/09

Date

Reception Screening (completed by receiving facility health care staff):

Facility: STACDate: 1/14/09Time: 1630 a.m. p.m.

Subjective:

Current Complaint: low morale in Qam

Assessment:

D Open Sores (eschar/lacer)
D1 Change dress.
T-H Appropriate

Objective:

Physical Appearance/Behavior: AEOX3

Plan/Disposition:

Health Information Given Emergency Referral: _____

Sick Call: Urgent / Routine Medication Evaluation Therapeutic Diet Special Housing Chronic Clinics

Work / Program Limitation Specialty Referrals Other (specify): _____

Infirmary Placement: _____

HIV Test & Counseling Offered (only transfers from R&C)

Other (specify): _____

Deficiencies: Acute/Chronic: DT: not medically indeterminate

Printed Name and Title

Signature

1/14/09

Date

For Adult Transition Center transfers only:

I understand that medical and dental care are my responsibility while I am housed in a transition center. I also understand that if I am in need of health care and I cannot afford to pay for it, I may be transferred back into a facility within the Department that can provide my medical, mental health, or dental needs.

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Stateville Correctional Center

Offender Information:

Shields
Last Name

Ernest

ID#: B6b161

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

PINCKNEYVILLE CORRECTIONAL

Center

Stateville
Joliet

Offender Information:

Shields

Last Name

Earnest

First Name

ID# B16161

M

Date/Time	Subjective, Objective, Assessment	Plans
3-3-09 11:00A	CMT NOTE miss the show for more will be needed. I hope	
4/17/09	CMT NOTE	
11A	S-I'm in pain all time. time, they were: Sopas to do surgery on my shoulder L.	P. F.U. PRN. Spoke to Dr Ghosh. matrix 80% only
	and they transfer me; B. Add 83 signs of distress Evaluated 12/17/08	
	① Surgery recommended refused 1/2 P.T. for shoulder requested medical Hold lifted	
	Last Just so could transfer D. Taylor CMT	

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

STA
PINCKNEYVILLE CORRECTIONAL Center

Offender Information:

SHIELDS

Last Name

ERNEST

First Name

ID# B660161

MI

Date/Time	Subjective, Objective, Assessment	Plans
4/28/09 11:40 AM	Subjective, Objective, Assessment	
	PA NOTE My glute in my shoulder is torn bad, my chest is really torn up, I can't hardly do anything, they told me I need surgery (has) my (L) side goes numb hard to sleep, I really took up something, I might have a blood clot 0 = gen = ml 1L = ml	1. Ibovirin 750mg - BID - \$30 2. Cont urofin 800mg as directed (has) 3. Don't atm sleep (has) 4. refer. to medical director for review evaluation 5. pt education / teachance not to get them ① pac
	Ext (R) pain chest expect 2 united atrophy plus to underarm. left to palp, Ranic discomfort	

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

PINCKNEYVILLE CORRECTIONAL Center

Offender Information:

Shields

Ernest

B66167

Last Name

First Name

MI

Date/Time	Subjective, Objective, Assessment	Plans
5/1/9	N.D.Mis.	
2-53P.	S - go injury to front of C chest m 7/2008 which lifting wt. 11M hard tear of pectoralis muscle (B)	P. Orthopedic commit. Low back P.D.M. return until 8-31-9
4-20 114/7D		Front cuffing return 117-9 8-31-9
	P 67 T 97. WT 200 lbs.	Abing permiss. until 8/31/9
4-20 114/7I		
	P 67 T 97 R 18 T 97 D	
(B) pectoralis enthesitis		
Movement of (B) shoulder in all directions		
A - (R) pectoralis		P67
Scars		

2-19-73 M/B

ILLINOIS DEPARTMENT OF CORRECTIONS
Medical Special Services Referral and Report

Stateville Correctional Center

(Facility)

Offender's Name: Shields Ernest

ID#

B66167

Reason for Referral: Consult Non-Formulary Medications Medical Equipment
 Evaluation Management
 Procedure/service (specify) _____
 Other (specify) _____

Urgent: Yes No

Referred to: WIC Orthopedic

7/31/09

Rationale for Referral:

(D) pectoralis tear muscle damage rupture
on 7/2005,

P644

Print Referring Practitioner's Name

P64

Referring Practitioner's Signature

5/31/09

Date

Findings:

(L) Pectoralis tear

No anterior muscle flap

Assessment:

(1) Pectoralis tear

chronic > 1yr

Recommendations/Plans: Pt is too far out for surgical intervention. He will need pain management and physical therapy - return as needed.

George Ozande

Print Practitioner's Name

George Ozande

Practitioner's Signature

7/31/09

Date

Facility Medical Director Use Only

I have reviewed the recommendations and:

Approve.

Deny or revise as indicated on the Notification of Medical Service Referral Denial or Revision, DOC 0255.

P. L. H. D. S. H.

Print Facility Medical Director's Name

P64

Facility Medical Director's Signature

7/31/09

Date

OneRadiology

Normal, Illinois 61761

June 24, 2008

Patient Name: Shields, Ernest

Patient No# B66161

DOB: 2/19/71

Dr. Migliorino

Hill Correctional Center

LEFT SHOULDER TWO VIEWS 6/16/08

INDICATION: Pain.

FINDINGS: The views of left shoulder show no bony or soft tissue abnormality.

IMPRESSION: Normal left shoulder.

CHEST ONE VIEW 6/16/08

INDICATION: Pain.

FINDINGS: Lungs are clear. Heart is normal. Bony thorax is unremarkable.

IMPRESSION: Normal chest.

Signed _____

C. Lee, M.D. DATE: 6/25/08
TIME REC: 1:00 pm
INITIAL DATE: 6/25/08

CL:eg

DIC: 6/24/08 Films from Hill Correctional Center

6/25/08
D:
C:
N.C.

ILLINOIS DEPARTMENT OF CORRECTIONS
Offender Health Status Transfer Summary

Transferring Facility:

Stateville Correctional Center

Date: 7.31.09

Offender Information:	
Last Name: <u>Shields</u>	First Name: <u>Ernest</u>
ID# <u>B66d61</u>	

Time: 1 p.m.

Transfer Screening (completed by transferring facility health care staff):

Allergies: NKACurrent / Acute Conditions / Problems: /Chronic Conditions / Problems: /

Current Medications (name, dosage, frequency, and duration):

Acute Short-term: /Chronic Long-term: /Chronic Psychotropic: /Current Treatments: /Therapeutic Diets: RegFollow-Up Care: RPCChronic Clinics: /Specialty Referrals: U of ISignificant Medical History: C.S.W. (2) foot & anklePhysical Disabilities / Limitations: /Assistive Devices / Prosthetics: ✓ back & gallery Glasses DenturesMental Health Issues: Hx Suicide Attempt Date: / Hx Psych Med Hx MPC/STCSubstance Abuse: Alcohol DrugsR & O Use Only: LAB EKG CXR Dental MEDS MH Other Packet CompletePrint Name and Title: Janet Stegall CMTS

Signature

Date 7.31.09

Reception Screening (completed by receiving facility health care staff):

Facility:

Subjective:

Current Complaint:

Current Medications/Treatment:

Date: / Time: / a.m. p.m.

Assessment:

Objective:

Physical Appearance/Behavior:

Plan: Disposition:

- Health Information Given Emergency Referral:
- Sick Call; Urgent / Routine
- Medication Evaluation Therapeutic Diet Special Housing Chronic Clinics
- Work / Program Limitation Specialty Referrals Other (specify):
- Inflammatory Placement
- Other (specify):

Printed Name and Title

Signature

Date /

For adult transition center transfers only:

I understand that medical and dental care are my responsibility while I am housed in a transition center. I also understand that if I am in need of health care and I cannot afford to pay for it, I may be transferred back into a facility within the Department that can provide my medical, mental health, or dental needs.

Offender's Signature

Date

Time

 a.m. p.m.

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Stateville Correctional Center

Offender Information:

Stueckle

Last Name

Earnest

First Name

ID#: B66161

MI

Date/Time	Subjective, Objective, Assessment	Plans
08-03-09 11-3 SA	MD not. Ijm was evaluated in the orthopedic clinic in the orthopedic clinic Impression from (R) deltoiditis muscle Not amenable to surgical repair	P No further F/N No medical proto / can transfus P61
8/29/09	Pt c/o continued pain	Spoke to Med
9A	shoulder & chest. Not a fair - permit surgical candidate. Renewal & consult	
11/11/09	Wants permits renewed suggestions in DAVT	R. Olist
144/93	So my (R) elbow "popped"	P1, stat x-ray
HR 88	10 days ago.. it is out of place	(R) Elbow.
T97	stick out on and off	
	U/L Ux 3 AM (R) elbow no bruise seen	
	A (R) elbow injury	12/04/09

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Stateville Correctional Center

Offender Information:

Shields

Last Name

First Name

ID#:

Date/Time	Subjective, Objective, Assessment	Plans
12/1/19	MD Note	
12/25/19 8:00 AM	S/O (R) Elbow x-ray shows ? avulsion Frx of olecranon process . radiology report pending	Pl. case dismissed with medical director. Permit for Low Back, Front cuffing, no gym yard.
	Elbow No red no marked edema no bruise .	Elbow brace one
	Rom guarded	Left arm slg givens
	Tender olecranon process	by medical director
	A (R) Elbow injury	Pl. may take tylenol or motrin for pain
	MD Note	P1/28/2020
12/3/19	S/O radiology report of (R) Elbow	
2:20 PM	No Fracture. Small bone spur of olecranon process of proximal ulna.	NOTES Fracture P1/28/2020
	A (R) Elbow injury , patient not seen .	Pl. A/C as
	Fx ruled out by radiologist	PT required if symptoms persisted 2 wks.

May 25, 2010 1:57PM SMU

No. 2943 P. 48

STATEVILLE CORRECTIONAL CENTER

FOR X-RAY TECH ONLY

STATE OF ILLINOIS - DEPARTMENT OF CORRECTIONS

X-RAY REPORT

Inmate's Name: Shields, Ernest Number: B66161 Date: 12/11/9
Age: 36

Reason for X-Ray: (R) Elbow stat

S/R dislocation or strain 10 days ago

Dr Zhang
Ordering Physician

Findings:

No fracture;
Small bone spur of olecranon process
of proximal ulna.

Date: _____

12/13/09 M.D.

FOR CORRECTIONAL CENTER HEALTH CARE UNIT PERSONNEL ONLY

I have reviewed the recommendations contained in this report.

Date: 12/3/9

PB
Signature and Title

IL 426-18393 DCA 42066

Southern Illinois University - School Of Medicine
Scheduling System - Appointment Confirmation

Provider: OLYSAV, DAVID MD

DQ340

ERNEST

Name: SHIELDS
Address: 600 LINWOOD RD
C/O HENRY HILL CORR CTR
GALESBURG IL 61401
Phone: 309-343-4212

Medrec Number: 820246
Date Of Birth: 02/19/1971 37
Sex: M
Work Phone: 309-343-4212 373

Case: OUTPATIENT
Where: SG SURGERY CLINIC 747-501
When: 08/26/08 at 09:00
Reason: 00 PECTORALIS RUPTURE
Comments: R/S D/T PER. DEB T FLG
Rpt To:

PT. FILMS/PER EMATL

Ref Dr.:

DR. S.
8/26/08

INSTRUCTIONS

MMC OR STJ FILMS BRING OUTSIDE FILM BRING INSURANCE CARDS AND COPAYS AT TIME OF VISIT

RECEIVED

Southern Illinois University - School Of Medicine
Scheduling System - Appointment Confirmation

Provider: OLYSAV, DAVID MD

DO340

Name: SHIELDS ERNEST
Address: 600 LINWOOD RD
C/O HENRY HILL CORR CTR
GALESBURG IL 61401
Phone: 309-343-4212

Medrec Number:
Date Of Birth: 02/19/1971 37
Sex: M
Work Phone: 309-343-4212 373

Case: O OUTPATIENT
Where: SG SURGERY CLINIC 747-501
When: 08/26/08 at 14:00
Reason: OO PECTORALIS RUPTURE
Comments: PER EMAIL
Rpt To: TO BG FILMS

Ref Dr.:

INSTRUCTIONS
MMC OR STJ FILMS BRING OUTSIDE FILM BRING INSURANCE CARDS AND COPAYS AT TIME
OF VISIT

RIS

SIU SCHOOL OF MEDICINE
DIVISION OF ORTHOPEDICS

MRH
820244

TO: NAME Natalie
LOCATION _____
FAX# 309 344 -8544

IMMEDIATE ACTION: YES

FROM: Nurses: I spoke with Dr. Oysaw. He said if he was O.K. to send pt for instructions for 2-3 visits until he can do P.T. on his own - call ~~any~~ me with any questions

SIU School of Medicine
Department of Surgery
PO Box 19679
Springfield, IL 62794-9679

Clinic Operator: (217) 545-5878
Clinic Fax: (217) 545-4189

COMMENTS:



Date: _____

Name: Ernest Shields

Times per week for _____ weeks

Diagnosis: P. pectoralis
major, rupture

Evaluate & treat

Physical Therapy Program:

Trunk flexibility and strengthening (McKenzie)

ROM to _____

Strengthening to aggressive P.

TRANSMISS:

Aerobic conditioning

Gait training

PAGES SEI

Including this page

This message is intended only for the use of the individual or entity to which it is addressed and may contain information that is confidential and/or privileged. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original to us at the address shown.

D. Oysaw
Physician Signature

JWL

SIU Physicians & Surgeons, Inc. Department of Surgery Outpatient Consult/New Outpatient Visit David J. Olysav, M.D.		ENC: 30025035 FC: SG PV: DO340 PS: SM OLYSAV, DAVID MD REF PT: EARNEST SHIELDS MR# 820246 37 08/26/08 DOB 02/19/1971 09:00 CS: O 15041570019 INS W25 GUR SOF: 08
Attending Physician	Resource Code	
Referring Physician	Referring Service	
OC: <i>Hernia, rupture</i>		NEW RETURN NEW PROBLEM
HISTORY PRESENT ILLNESS (HPI) Brief 1-3 * Ext ≥ 4 Location, Quality, Severity, Duration/Timing, Context, Modifying factors, Assoc. signs & Ex		
HPI (required)		<i>fecal mass (e - 18 + yrs) contay in abdomen 300+ gms + painless, right-sided (-) no nausea</i>
ROS	Prob Focus none	Exp Prob 1 Detailed 2-9 * Comp > 10 or some with "all others negative"
Constitutional	neg abn	GI neg abn Psychiatr neg abn
Eyes	neg abn	GU neg abn Endocrine neg abn
ENT	neg abn	Musculoskeletal neg abn Hematol/Lymph neg abn
Cardiovascular	neg abn	Skin neg abn Allergol/Immun neg abn
Respiratory	neg abn	Neurologic neg abn ROS unobtainable
Other systems negative		
<i>FE 90 / 150° AB 95 / 110° EXT 25° 5/5</i>		<i>5/5 strength</i>
* Past, Family, & Social History (PFSH) Pertinent = 1 from any 3, Complete = all 3		
PAST MEDICAL HX:	FAMILY HX:	SOCIAL HX:
Unobtainable	Unobtainable	Unobtainable
Non-contributory	Non-contributory	Non-contributory
<i>ALLERGIES</i>		
		Marital Status M S D
		Children Y N
		Tobacco Y N Quil Y N
		ETOH Y N Drug Use Y N
MEDICATIONS:		Allergies: (Medication(s), Food, Metals, Other) <i>✓ NKDA</i>
		Past Surg Hx: <i>ANKLE (L) GSJ</i>
		<i>Fracture site</i>

*Needs PT
for ROM & Strength*

*(1) (2) feet and toes
PT/OT room*



Illinois
Department of
Corrections

Hill Correctional Center / 600 Linwood Road / P.O. Box 1327 / Galesburg, IL 61401 / Telephone: (309) 843-4212 / TDD:
(800) 626-0844

Rod R. Blagojevich
Governor

Roger E. Walker Jr.
Director

MEMORANDUM

DATE: August 19, 2008

TO: Infirmary Staff

FROM: Lois Mathes, RN/HCUA

Medical Furlough has been scheduled as delineated below:

NAME: Shields, Ernest

IDOC#: B66161

D.O.B: 2-19-71

DATE: 8-26-08

LEAVE TIME: 6:15a.m.

REFERRING PHYSICIAN: Dr. Migliorino/Dr. Funk

REASON FOR FURLOUGH: Ortho. Eval. (Pectoralis Tendon Rupture Left Shoulder).

LOCATION: Dr. Olysav's Office

STREET: 747 N. Rutledge/Baylis Building 5th Floor

CITY/STATE/ZIP: Springfield, IL 62703

TELEPHONE NUMBER: (217) 545-5878

SAME DAY RETURN: X

ADMISSION:

EMERGENCY:
AMBULANCE:

1. Complete HS Report - Given to SA
2. MAR'S to Infirmary
3. Sign consent for TX/Operation Form
4. T.P./Admit to Infirmary

Prep Needed: Bring copies of all reports and x-ray film to appt. that is pertaining to problem.

Cc: Records Office
7/3 Shift Commanders
Medical File
X-Ray
File

Offender's Name: Shields, Ernest

ID# B66161

Facility
Physical, Mental Health and Medical Report
Medical Referral/Medical Service Referral Report

SLC

Reason for Referral:

- Consult Non-Formulary Medications Medical Equipment
 Evaluation Management
 Procedure/service (specify) _____
 Other (specify) _____

Urgent: Yes No

Referred to: Dr. Olyar/PT/C

left shoulder

Rationale for Referral:

Ortho. Eval. (Pectoralis Tendon Rupture)

Print Referring Practitioner's Name: MIGLIARO

Referring Practitioner's Signature: D. Olyar

Date: 2/2/08

Report of Referral (Use Reverse Side, if necessary)

Findings:

Humerals by Shoulder (C)

Assessment:

Fight — 7 wks

Needs PT: for Pectoralis Strengthening

Recommendations/Plans:

P.T. (C) Shoulder.

Pectoralis Strengthening

Print Practitioner's Name: D. OLYAR

Practitioner's Signature: D. Olyar

Date: 2/2/08

Facility Medical Director Use Only

I have reviewed the recommendations and:

- Approve.
 Deny or revise as indicated on the Notification of Medical Service Referral Denial or Revision,
DOC 0255.

Print Facility Medical Director's Name

Facility Medical Director's Signature

Date

Wexford Health Sources]]

Subject: [Fwd: [Fwd: Wexford Health Sources]]
From: Lynn Singleton <lsingleton@siunmed.edu>
Date: Fri, 22 Aug 2008 10:45:37 -0500
To: Janice Herman <jherman@siunmed.edu>

AMM 15
DOS: 08/26/08 PV: DO340
MR#: 820246
PT: EARNEST
SHIELDS
DOB: 02/19/1971

----- Original Message -----
Subject: [Fwd: Wexford Health Sources]
Date: Tue, 19 Aug 2008 09:22:37 -0500
From: Judie Riesch <jriesch@siunmed.edu>
To: Lynn Singleton <lsingleton@siunmed.edu>

Lynn -- Forwarding e-mail sent to you last Friday. Just received a call from the Call Center saying they did not have authorization to make this appointment and transferred the call to me. Can you rectify? I have confirmed approval with correctional center for EARNEST SHIELDS, #B-66161 and asked them to call the CALL CENTER back in 30 minutes.

Thank you.

----- Original Message -----
Subject: Wexford Health Sources
Date: Fri, 15 Aug 2008 15:53:20 -0500
From: Judie Riesch <jriesch@siunmed.edu>
To: Lynn Singleton <lsingleton@siunmed.edu>, Cheryl McGill <cmcgill@siunmed.edu>

SIU P&S has signed an agreement to provide medically necessary and authorized evaluation, treatment, and follow up care for the following:
Earnest Shields -- #B-66161 -- by Orthopaedic Surgery -- for Rectoraditis Rupture

Original agreement is being forwarded to Patient Billing Services

Thank you,
Judie Riesch
SIU P&S Admin. Office
545-8850

SIU HealthCare

Page 1

217-545-8000 Fax: Chart Document

June 30, 2010

EARNEST SHIELDS

4212873

39 Years Old Male (DOB: 02/19/1971)

MRN #: 820248 Home: (309)999-9999 Office: (309)343-

452216-2155001 Inst: WEXFORD (W26)

09/12/2008 - Phone Note

Provider: David J Olysv, MD

Location of Care: SIU HealthCare

Ok for PT to instruct 2-3 times for home PT per Dr. Olysv

Rx and note faxed to Natalie.

--- Converted from flag ---

--- 09/06/2008 4:25 PM, Katherine McMullin wrote:
Returned call and they had left already will return call again Monday am

--- 09/04/2008 2:08 PM, Katherine McMullin wrote:

--- 09/04/2008 1:55 PM, Beth Ann Peters wrote:

Is it for one time or does he have to go 2 to 3 times a week. Please call back by tomorrow. They need to know because he has collegial. Please call Natalie w/ Henry Hill Correction Center at 309-343-4212 ext 373 and she leaves at 4. Thanks

Clinical Lists Changes

Signed by Katherine McMullin on 09/12/2008 at 4:37 PM

Signed by David J Olysv, MD on 09/16/2008 at 7:57 AM

June 30, 2010

EARNEST SHIELDS	MRN #: 820246	Home: (309)999-9999	Office: (309)343-
4212373 39 Years Old Male (DOB: 02/19/1971)	452216-2155001	Ins: WEXFORD (W26)	

08/28/2008 - Transcription: EMDAT Clinic Note

Provider: John Froelich, M.D.

Location of Care: SIU HealthCare

EMDAT Clinic Note

CHIEF COMPLAINT: Left pectoralis major rupture.

HISTORY OF PRESENT ILLNESS: This is a 37-year-old gentleman who is a member of the Corrections Institution who was bench pressing on June 18, 2008, felt a sudden pain in his left arm and had a audible popping sound. Noted some numbness in his arm. He was evaluated in the local emergency room. Then MRI of the shoulder showed no significant injury other than a mild supraspinatus tear per a written documentation as the MRI is not here. He states that he continues to have numbness and night pain as well as discomfort. He had seen orthopedic surgeons who said they would not treat this injury on him. The patient is here for another opinion. He has not been doing any physical therapy or activity. He has been using a sling for sometime.

PAST MEDICAL HISTORY: History of meningitis as a child.

PAST SURGICAL HISTORY:

1. Repair of the left ankle after GSW.
2. History of multiple spinal taps.

MEDICATIONS: None.

ALLERGIES: NO KNOWN DRUG ALLERGIES.

SOCIAL HISTORY: He is currently under the correctional system. Denies use of tobacco.

PHYSICAL EXAMINATION:

General: The patient is in no acute distress. Answers questions appropriately. Alert and oriented and appears stated age.

HEENT: Normocephalic, atraumatic. Gross extraocular movements are intact.

Cardiovascular: Regular.

Pulmonary: Unlabored.

Abdomen: Soft.

Musculoskeletal: Examination of the left shoulder shows no tenderness to palpation of the AC joint, the distal acromion, or the anterior biceps. He has forward flexion of 90 degrees active, passive 130 degrees, abduction active 75 degrees, passive 110 degrees, external 25 degrees active with 5/5 strength. He has 5/5 strength to the supraspinatus and 5/5 internal rotation. He is unable to get his arm to the back pocket position.

Digital examination of the shoulder shows palpable and visual defect in the pectoralis distribution. He is tender to palpation over the anterior chest with retraction of the pectoralis. When the patient does internally rotate the pectoralis does fire on his chest but in view there is a obvious palpable and visual defect and it does not insert on to the humerus at this time. There is no excessive swelling on that.

SIU HealthCare

Page 1

217-545-8000 Fax: Chart Document

June 30, 2010

EARNEST SHIELDS 4212373 39 Years Old Male (DOB: 02/19/1971)	MRN #: 820246 452216-2155001	Home: (309)999-9999 Ins: WEXFORD (W25)	Office: (309)343-
---	---------------------------------	---	-------------------

side versus the right.

IMAGING: MRI is not obtainable in the office today. The patient has plain films of the arm. Two views of the shoulder AP and oblique which show no fracture noted.

ASSESSMENT AND PLAN: This is a 37-year-old gentleman with a ruptured left pectoralis major. At this time, we will encourage the patient to do aggressive PT with strengthening as he has deconditioned the area as well as has lost range of motion in that arm.

Electronically Signed By:
John M. Froelich, M.D.

Resident

The following text was appended to the transcription:
I saw and personally examined the patient and discussed the case with the resident. I have reviewed the resident's note and agree with the content and plan as written except as follows: none.

Electronically Signed By:
David J. Olyar, M.D.

Associate Professor of Clinical Surgery

Signed before import by John Froelich, M.D.
Filed automatically on 09/02/2008 at 12:08 PM

Orthopedic Consult**SHIELDS, EARNEST - 80621578***** Final Report ***

Result Type: Orthopedic Consult
Result Date: July 31, 2009 12:00 AM
Result Status: Modified
Result Title: Letter/Consultation- ATTENDING: Benjamin A Goldberg, MD
Performed By: Ozoude MD, George on July 31, 2009 7:52 PM
Verified By: Ozoude MD, George on August 03, 2009 6:26 AM

*** Final Report ***
Document Contains Addenda

Letter/Consultation- ATTENDING: Benjamin A Goldberg, MD (Verified)

University of Illinois Medical Center at Chicago

LETTER/CONSULT

PATIENT: SHIELDS, EARNEST

DICT: GEORGE OZOUDE, MD
ATTNG: BENJAMIN A GOLDBERG, MD

MRN: 080621578
DATE OF SERVICE: 07/31/2009

July 31, 2009

RE: SHIELDS, EARNEST
MR# 080621578

SUBJECTIVE: This is a 36-year-old male who has had a longstanding left chest deformity from a torn pectoralis muscle. He injured it while lifting 375 pounds of a bench press bar. The patient has worsening pain that has not improved with medications for the past year. He has decreased function of the arm due to weakness.

OBJECTIVE: Decreased anterior axillary fold seen on exam. Weakness with internal rotation of the hand and arm compared to the right side. Gross deformity of the inferior aspect of the breast tissue.

ASSESSMENT AND PLAN: This is a 36-year-old male with a chronic torn pectoralis muscle. The patient was seen by several different orthopedic surgeons in the past year, all of which have determined that they do not do that type of surgery. The patient presented to us on this day with chronic tear that is not amenable to surgical repair. The patient was upset with the decision making. He was explained that his condition was not amenable to

Printed by: Rodriguez , Yolanda
Printed on: 5/6/2010 2:40 PM

Page 1 of 2
(Continued)

Orthopedic Consult

SHIELDS, EARNEST - 80621578

* Final Report *

repair, however, he could explore the option of cosmetic intervention. We further explained that there would be no further function gained if we were to go ahead and repair the pectoralis muscle. The patient verbalized understanding of the assessment and plan. The patient was seen and discussed with Dr. Goldberg who agrees with assessment and plan.

Benjamin A Goldberg, MD

George Ozoude, MD

DD: 07/31/2009 19:52:58
DT: 08/02/2009 21:37:06
GO/MedQ
JOB: 819147/382047969

Addendum by Goldberg MD, Benjamin on August 07, 2009 12:44 PM (Verified)

I was present with resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident's note

Completed Action List:

- * Perform by Ozoude MD, George on July 31, 2009 7:52 PM
- * Transcribe by on August 02, 2009 9:37 PM
- * Sign by Ozoude MD, George on August 03, 2009 6:26 AM Requested on July 31, 2009 7:52 PM
- * VERIFY by Ozoude MD, George on August 03, 2009 6:26 AM
- * Sign by Goldberg MD, Benjamin on August 07, 2009 12:44 PM Requested by Ozoude MD, George on August 03, 2009 6:26 AM
- * Modify by Goldberg MD, Benjamin on August 07, 2009 12:44 PM

Printed by: Rodriguez , Yolanda
Printed on: 5/6/2010 2:40 PM

Page 2 of 2
(End of Report)

ILLINOIS DEPARTMENT OF CORRECTIONS
Medical Special Services Referral and Report

2008C
(Facility)

Offender's Name: Shields, Ernest ID# B66161

Reason for Referral: Consult Non-Formulary Medications Medical Equipment
 Evaluation Management
 Procedure/service (specify) _____
 Other (specify) _____

Urgent: Yes No

Referred to: Dr Scherer

Rationale for Referral: left shoulder injury eval.

Print Referring Practitioner's Name

Referring Practitioner's Signature

Date

Findings: Ruptured (L) pectoralis tendon

Assessment: Ruptured (L) pectoralis tendon

Recommendations/Plans: Needs to see shoulder specialist. Report to follow

Print Practitioner's Name

Practitioner's Signature

Date

Facility Medical Director Use Only

I have reviewed the recommendations and:

- Approve.
 Deny or revise as indicated on the Notification of Medical Service Referral Denial or Revision, DOC 0255.

Print Facility Medical Director's Name

Facility Medical Director's Signature

Date

June 23, 2008

Henry Hill Correctional Center

Dr. Shute

600 Linwood Road

Galesburg, IL 61401

REF: EARNEST SHIELDS

Dear Dr. Shute:

Enclosed are my office notes of 06/23/08 concerning Earnest Shields. He has a pectoralis tendon rupture of the left chest and shoulder. He needs to see a shoulder specialist for surgery. I have not performed this surgery in the past.

If you have any questions, please contact me.

Sincerely,

Gregory A. Schierer, M.D.

GAS/jlh

Enclosure

06/23/08 EARNEST SHIELDS 111453.0

This 34 year old is a prisoner at Henry Hill Correctional Center. He was lifting weights on 06/18/08 when a weight dropped and he injured his left chest. He felt something snap. He has had ecchymosis of the left proximal humeral area and lateral chest near the axilla on the left side. He is complaining of constant pain, worse with activity.

Past Medical History: The patient has had a gunshot wound in the past.

Medications: Motrin.

Allergies: None.

Family History: Not contributory to this problem.

Social History: Habits: tobacco and alcohol - none. The patient is a prisoner.

Review of Systems: No other complaints voiced.

Physical Examination: The patient is 5'8" and weighs 185 pounds. The left shoulder shows ecchymosis of the proximal humerus and the axilla. There is tenderness of the pectoralis insertion. There is an obvious rupture of the pectoralis tendon. The patient has weakness of adduction of the left shoulder. He has pain with passive abduction.

Assessment: Pectoralis tendon rupture left shoulder.

Plan: This injury requires treatment by a shoulder specialist. I do not

have the expertise to perform the surgery necessary to treat this problem.

Gregory A. Schierer, M.D./jlh

ORTHOPEDIC INITIAL HISTORY

WC INS LIAB IME

Date 6/23/08 Patient ERNEST SHIELDS Acct # _____ Phone 343-4212

Age 34 M F Height 5'8 Weight 185 B/P / Pulse _____

Did you bring: X-RAYS MRI ESI CT EMG BONESCAN Other _____

Who requested you visit this office? Doctor SUTURE + Funck Attorney _____ Self-Referral

What is the main reason for this visit? Pain Numbness Weakness Other

Neck	Shoulder L <input checked="" type="checkbox"/> R <input type="checkbox"/>	Elbow L <input type="checkbox"/> R <input type="checkbox"/>	Hand L <input type="checkbox"/> R <input type="checkbox"/>	Pelvis L <input type="checkbox"/> R <input type="checkbox"/>	Knee L <input type="checkbox"/> R <input type="checkbox"/>	Foot L <input type="checkbox"/> R <input type="checkbox"/>	
Back	Mid <input type="checkbox"/> Low <input type="checkbox"/>	Arm L <input type="checkbox"/> R <input type="checkbox"/>	Wrist L <input type="checkbox"/> R <input type="checkbox"/>	Finger L <input type="checkbox"/> R <input type="checkbox"/>	Hip L <input type="checkbox"/> R <input type="checkbox"/>	Ankle L <input type="checkbox"/> R <input type="checkbox"/>	Toe L <input type="checkbox"/> R <input type="checkbox"/>

How long has this problem been present? _____ Occupation _____ Emplyr _____ Status _____

How did your problem start:

- No Injury
- Gradual or sudden
- Injury - Other
- Where and how
- Injury at work
- Where and how
- Work Related but no injury
- How did job cause problem
- Auto Accident
- Where and how

Please describe		Date of occurrence
<input type="checkbox"/>	LIFTING AND DROPPED WEIGHTS	6/18/08
<input checked="" type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		

The pain is Constant Comes and goes _____

Severity of pain Mild Moderate Severe Extremely Severe

Quality of pain Sharp Dull Stabbing Throbbing Aching Burning

Associated Symptoms Swelling Numbness Weakness Other
 Popping Grinding Catching

Since the problem started Better Worse Unchanged Does the pain wake you from sleep Y N

What makes the symptoms worse? Activity Exercise Work Stairs Other _____

Which make you feel better? Rest Heat Ice Elevation Other _____

What medications have you taken or been prescribed for this condition? MOTRIN

What Treatments have you tried? Injections Brace Therapy Cane/Crutch Other _____

What Pharmacy do you use? Name: _____ Phone: _____

Address: _____ Zip: _____

REVIEW OF SYMPTOMS: Do you have now, or have you ever had, any of the following health problems?

1) M/S Have you had a prior problem with this same Orthopedic condition in the past Y N (explain below)

Have you had any prior back pain joint swelling fracture arthritis

2) ARE YOU ALLERGIC TO ANY MEDICATIONS Y N If yes please list _____

3) ARE YOU A DIABETIC? Y N TREATMENT: Insulin Oral meds Diet None

				NONE	YEAR	EXPLAIN DETAIL
4) CON	weight loss	loss of appetite	fever	cancer	<input checked="" type="checkbox"/>	_____
5) EYE	<u>glasses</u>	Contacts	Double vision	Cataract	<input type="checkbox"/>	_____
6) ENT	hearing loss	Hoarseness	Ringing in ears		<input checked="" type="checkbox"/>	_____
7) CV	high blood pressure	Heart attack	blood clots		<input checked="" type="checkbox"/>	_____
8) RS	asthma	cough	pneumonia	SOB	<input checked="" type="checkbox"/>	_____
9) GI	stomach ulcer	hepatitis	blood in stool		<input checked="" type="checkbox"/>	_____
10) GU	pain w/ urination	blood in urine	kidney disease		<input checked="" type="checkbox"/>	_____
11) SK	skin ulcers	rash	lumps		<input checked="" type="checkbox"/>	_____
12) NEU	seizures	stroke	balance prob	headaches	<input checked="" type="checkbox"/>	_____
13) PSY	depression	nervousness	sleep disorder		<input checked="" type="checkbox"/>	_____
14) HEM	easy bleeding	easy bruising	anemia		<input checked="" type="checkbox"/>	_____

PAST MEDICAL HISTORY

What medications do you take? None Please list w/dosage MOTRIN + PAIN PILLS

Are you taking or have you ever taken blood thinners? Y N If yes, what type _____

Past surgical history: What operations have you had? When: ANKLE + LOWER BACK - GUN SHOT

Have you ever had a reaction to anesthesia? Y N _____

FAMILY HISTORY: Have any direct relatives had any of the following disorders? If so, which relative

Any direct relative with the same Orthopedic condition you are being seen for today Y N

Diabetes Y N High blood pressure Y N Heart disease Y N Arthritis Y N Cancer Y N

SOCIAL HISTORY:

Do you use tobacco? Y N Alcohol use? Y N How often? Daily Weekly

Marital History: M S D W How many people live with you? _____

ASSESSMENT

Shake
shoulder spine

PLAN

SL 6/23/08
date

Nurse _____ / Doctor _____

date

Galesburg Cottage Hospital
695 N. Kellogg St.
Galesburg, IL 61401

Patient Name:	SHIELDS, EARNEST D	Room Number:	EOP
Medical Record #:	418894	Patient Number:	5290082
Date of Service:	06/16/2008	DOB/SEX:	2/19/1971 / M
Ordering Physician:	BOMMIASAMY VEERASIKKU MD	Admitting Physician:	BOMMIASAMY VEERASIKKU MD

RADIOLOGY REPORT
MAGNETIC RESONANCE IMAGING OF THE LEFT SHOULDER

HISTORY: The patient was weight-lifting today and heard a "pop" resulting in limited range of motion and pain in the shoulder joint.

TECHNIQUE: Sequences as listed.

FINDINGS: There is moderate increase in signal intensity within the distal supraspinatus - rotator cuff tendon, compatible with moderate tendinosis and/or partial tear. There was no abnormal fluid within the glenohumeral joint or subacromial - subdeltoid bursa. The glenoid labrum appears intact. Marrow space signal intensity of the visualized humeral head and glenoid process appear within normal limits. The bicipital tendon appeared within the bicipital groove.

SUMMARY:

MODERATE TENDINOSIS AND/OR PARTIAL THICKNESS TEAR SUPRASPINATUS - ROTATOR CUFF TENDON.
MILD DEGENERATIVE CHANGES LEFT ACROMIOCLAVICULAR JOINT WITH MINIMAL INDENTATION ON THE ROTATOR CUFF MUSCULOTENDINOUS STRUCTURES.

STEPHEN LEHNERT MD

Electronically Signed on 6/17/2008 1:40 PM by Stephen Lehnert, MD

RADIOLOGY REPORT

DD: 6/17/2008 11:02

TT: 6/17/2008 11:38

Printed At: 6/20/2008 11:08

SL / 639

Page 1 Of 1

Job #: 2754135

MANUALLY PRINTED BY USER

Jun. 16, 2008; 6:09PM ~~06/16/08~~ Radiology

Jun. 16, 2008 5:53PM Radiology

Emergency Hospital

STEPHEN LEHNERI MD

No. 5050 P. 1 01/01

No. 5047 P. 2

Number: 5290082
Name: SHIBLODS TARNEST D
Rm/Bed: 0/P / ADP
Admit: 6/16/08
DX: SHOULDER INJURY
Sex/Race: M-B
DOB: 2/19/71
Age: 37
Ht/Wt: 5'10" 188 lbs
Chart#: 418894

Ordering Dept: RAD
Order Dt/Tm: 6/16/08 17:04
Order Status: ROUTINE
Start Dt/Tm: 6/16/08 17:04
Keyed By: CSMWMPRS
Order Phys: BOROMILASAMY VENKATESH
Admit Phys: BOROMILASAMY VENKATESH
Primary Phys:
Jacket #: 1

TRANSPORT: WALK
IV/O2?: NONE
LNP?: NA
EEG?: B/C? EE

000418894

Last Exam Date:

200 MR-UPPER EXTREMITY

RIGHT

LEFT

ISOLATION: NONE

COMPLETE MR SAFETY FORM
Pain

MRI L Shoulder - moderate tendinosis
or partial tear supraspinatus tendon

otherwise Ø

S Lehner, MD

END OF PAGE

Mo p. 73

O.P. NUMBER

DATE

SHIEL IS PRESENT

Galesburg Cottage Hospital

695 N. Kellogg St. • Galesburg, IL 61401 • 309-343-8131

FOLLOW-UP INSTRUCTIONS

- Follow-up & Re-evaluation in _____ hours, _____ days, _____ weeks.
 Call for appointment.
 Appointment has been made for _____ for PHYSICIAN _____
 ADDRESS _____
 PHONE _____
 OP Tests _____
- Call your MD's office in 72 hours for your final culture report.
 X-rays do not always show injury or disease, and fractures may not be revealed on the initial x-rays. If the problem persists or worsens, additional x-rays or tests may be required. If this occurs, you should contact your physician or return to the ER. Your initial x-ray reading is a preliminary report. The radiologist will make a final reading. You will be informed if there is any significant difference from the preliminary reading.
 For Workman's Compensation patients see company MD within 24 hours for follow-up.
 The physician services in the Galesburg Cottage Hospital Emergency Department are provided by Advanced Emergency Specialists, an independent contractor. The physicians comprising this group are not agents or employees of Cottage Hospital. The examination and treatment you have received in the Emergency Department has been rendered on an emergency basis only, and is not intended to be a substitute for, nor an effort to provide complete medical care. Because it is impossible to recognize and treat all elements of an injury or illness in a single emergency visit, it is important that you follow-up with your physician or the referral physician for your safety. Follow the instructions outlined below. If your present condition persists or worsens please contact the physician listed below. If unable to contact this physician you may return to the Emergency Department at any time.

PROVISIONAL DIAGNOSIS

RASH ON CERVIX UNK

OTHER SPECIFIC INSTRUCTIONS:

SLING
ICE
COOL PT INJ UNK

IT IS VERY IMPORTANT FOR YOU TO FOLLOW-UP AS DIRECTED, ESPECIALLY IF YOUR CONDITION PERSISTS, OR WORSENS, OR YOU DEVELOP NEW SYMPTOMS.

I HEREBY ACKNOWLEDGE RECEIPT OF AND UNDERSTAND THE PRINTED AND VERBAL INSTRUCTIONS.

X Ernest Shiel

SIGNATURE OF PATIENT OR RESPONSIBLE PERSON

SIGNATURE OF NURSE

Galesburg Cottage Hospital

309-343-8131

695 N. Kellogg St.

Galesburg, IL 61401

FOR _____

DATE _____

ADDRESS _____

Rx _____

SHIEL IS PRESENT

May Substitute _____

May Not Substitute _____

May Be Resubmitted _____

DEAN NO. _____

2

NR

GENERAL INSTRUCTIONS

- Persistent pain or disability for more than 72 hours are caution signs; notify your physician for further evaluation.
 Your eye has been patched. Please remove the patch in _____ hours. DO NOT DRIVE, as your ability to perceive depth will be impaired and your field of vision restricted.
 Ace/Splint
 Keep injured part at rest and elevated as much as possible.
 Ice intermittently to injured area for 24 hours. (On for 20 minutes then off for 20 minutes, etc.) Place cloth between ice bag to protect skin.
 Use heat.
 No weight bearing until okayed by your own physician, use crutches as directed.

MEDICATIONS

- Medications per reconciliation process.
 Due to medication you have been given in the emergency department, your alertness may be impaired and you may be drowsy. Do not drive, operate potentially dangerous machinery, or climb heights for 8 hours.
 Ibuprofen (Motrin, Advil) Adults: _____ milligrams, # _____ every _____ hours. Please stop ibuprofen if you should develop abdominal pain, blood in your stools or black stools. DO NOT USE IF ALLERGIC.
 Acetaminophen (Tylenol) Adults: _____ milligrams, # _____ every _____ hours. DO NOT USE IF ALLERGIC.

WOUND CARE INSTRUCTIONS

- Follow-up with your own MD within 1 to 2 days for wound check. Call for appointment.
 Keep dressing clean and dry.
 Observe for signs of possible infection which include: Redness, swelling, heat, red streaks, pus and/or drainage, increased pain, unexplained fever. CONTACT YOUR DOCTOR IMMEDIATELY IF THESE OCCUR.
 Arrange for suture removal in _____ days.

SPECIAL CARE INSTRUCTIONS

- Drink lots of cool fluids, water and juices etc. # Ounces _____ Per _____
 Take temperature every 2 - 4 hours.
 Extra rest.
 Call physician immediately if seizures or convulsions occur or if a rash develops.

OTHER FOLLOW-UP

- | | | |
|--|---|---|
| <input type="checkbox"/> Cold/flu, sore throat, cough | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Otitis Media Sheet |
| <input type="checkbox"/> Orthopedic injury care | <input type="checkbox"/> Back pain | <input type="checkbox"/> Animal Bite Sheet |
| <input type="checkbox"/> STD instructions | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Immunization |
| <input type="checkbox"/> Burn Care | <input type="checkbox"/> Heat and Cold emergencies | Card Given |
| <input type="checkbox"/> Respiratory care, croup, asthma | <input type="checkbox"/> Vomiting/diarrhea in adults | <input type="checkbox"/> |
| <input type="checkbox"/> Fever care instructions | <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> |
| <input type="checkbox"/> Head Injury Sheet | <input type="checkbox"/> Bites | <input type="checkbox"/> |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> General pediatric instructions | <input type="checkbox"/> |
| <input type="checkbox"/> Post Nosebleed Information | <input type="checkbox"/> Fever/Med Sheet | <input type="checkbox"/> |

Form # 8600173 (Rev. 5/00)

Galesburg Cottage Hospital

309-343-8131

695 N. Kellogg St.

Galesburg, IL 61401

FOR _____

DATE _____

The above was seen, treated, and released from our Emergency Department. I recommend:

- Release from usual/all employment responsibilities for _____ days.
 Release from participation in school classes/physical education / athletics for _____ days.
 Immediate return to work/school.
 Restrictions: _____

M.D. _____

ILLINOIS DEPARTMENT OF CORRECTIONS
Offender Health Status Transfer Summary

Med. Facil.
6-23-08
27-7:15am

Transferring Facility:
HHC Center

Offender Information:	
<u>Shields</u>	Last Name
<u>Ernest</u>	First Name
MI	
ID#: <u>B6A101</u>	

Date: 6/21/08 Time: 1425 a.m. p.m.

Transfer Screening (completed by transferring facility health care staff): HIV Test & Counseling Offered (only transfers to ATC, parole, release or discharge)

Allergies: N/A

Food Handler Approved: 2-26-CBysk

Current / Acute Conditions / Problems: end of R shoulder injury

Chronic Conditions / Problems:

Current Medications (name, dosage, frequency, and duration):

Acute Short-term: Motrin 800mg TID PRN 6/17/08

Chronic Long-term: O

Chronic Psychotropic: O

Current Treatments: O

Therapeutic Diets: Gen

Follow-Up Care: per ortho

Chronic Clinics: O

Specialty Referrals: Ortho

Significant Medical History: ZOC 1 G SH (2) for years

Physical Disabilities / Limitations: O

Assistive Devices / Prosthetics: O

Glasses Dentures

Mental Health Issues: Hx Suicide Attempt: Date: / / Hx Psych Med Hx MPC / STC Substance Abuse: Alcohol Drugs

R&C Use Only: LAS EKG CXR Dental MEDS MH Other

Packer Complete

Leda Parish RN

MR

6/29/08

Date

Print Name and Title

Signature

Reception Screening (completed by receiving facility health care staff):

Facility:

Date: / /

a.m.

p.m.

Subjective:

Current Complaint:

Assessment:

Current Medications/Treatment:

Physical Appearance/Behavior: _____

Deformities: Acute/Chronic: _____

Objective: _____

Plan: Disposition: _____

Health Information Given Emergency Referral: _____

Sick Call: Urgent / Routine Therapeutic Diet Special Housing Chronic Clinics

Medication Evaluation Work / Program Limitation Specialty Referrals Other (specify): _____

Work / Program Limitation Infirmary Placement: _____

Specialty Referrals Other (specify): _____

Infirmary Placement: _____

Other (specify): _____

HIV Test & Counseling Offered (only transfers from R&C) Other (specify): _____

Other (specify): _____

Printed Name and Title

Signature

/ /

Date

For Adult Transition Center transfers only:

I understand that medical and dental care are my responsibility while I am housed in a transition center. I also understand that if I am in need of health care and I cannot afford to pay for it, I may be transferred back into a facility within the Department that can provide my medical, mental health, or dental needs.

Offender's Signature

Date

Time

a.m. p.m.

NEW PATIENT INFORMATION GALESBURG ORTHOPEDIC SERVICES, LTD

Date 6/23/08 Patient Name Ernest Shields Driver's License # _____
Street 600 Lenwood City Galesburg
State IL Zip 61401 Employer _____
Work Phone _____
Home Phone 343-4212 SS# _____ Date of Birth 2-19-72
Emergency Contact Mother JoAnn Shields
Relationship Mother Phone # (723) 464-2771
Spouse's Name Shields SS # _____ Employer _____
Family Physician _____
Were you referred by a physician? Who? DR. STURGE / DR. FUNK

If Minor, responsible party and address _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Medicare/Public Aid # _____

Name of Commercial Group Ins: _____

Address _____

Ins Co Phone # _____

Insured's Name _____

Insured's SS # _____

Insured's Date of Birth: _____

Group Number: _____

Effective Date _____

Insured's Employer Name and Address: _____

SECONDARY INSURANCE

Medicare/Public Aid # _____

Name of Commercial Secondary Ins: _____

Address _____

Ins Co Phone # _____

Insured's Name _____

Insured's SS # _____

Insured's Date of Birth: _____

Group Number: _____

Effective Date: _____

Insured's Employer Name and Address: _____

WORK INJURY ONLY: (please answer all questions)

Date of Workcomp injury or first symptoms occurred _____

How accident happened _____

Have you ever had same or similar condition? Y / N If yes, state when and

Describe _____

Currently Working? Y / N If No, date first disabled _____

Have you filed a claim with your employer? Y / N Claim Number _____

Name and address of Workers comp insurance to be billed _____

LIABILITY OR AUTO INJURY ONLY:

Date of injury or first symptom occurred _____

How did accident happen _____

Are you currently working Y / N Name and address of party involved _____

Name and address of insurance to be billed _____

Policy and Claim Numbers _____

ATTORNEY INFORMATION, if any _____

Welcome and Thank you for choosing Galesburg Orthopedics

Galesburg Orthopedic Services, Ltd.

FINANCIAL POLICY

Thank you for choosing Galesburg Orthopedic Services, Ltd. for your healthcare needs. The following information describes our financial policy and information about our billing and insurance services. This form must be read and signed prior to treatment.

Private Insurance / Medicare-Medicaid / Managed Care: As a courtesy to our patients your charges will be filed with your insurance company. All co-pay and deductible amounts must be paid at the time of service. You must provide a current and valid insurance card and all applicable information pertaining to your claim. We accept Medicare Assignment and will file with Medicare and your secondary insurance on your behalf. If you are a member of a managed care plan, it is your responsibility to verify our participation in your network and that any necessary referrals and precertifications are completed. Balances over 60 days past due will become the responsibility of the patient and you will be billed directly. We reserve the right to accept or deny assignment of insurance benefits. We accept cash, check, Visa and MasterCard.

Workers Compensation / Accidents / Personal Injury: If you are being seen due to a work related injury, an accident or injury where another party is liable, your claims will be filed with the applicable insurance carrier. You must provide all pertinent insurance information including employer, claim number and the claim adjusters contact information. We will also ask you to provide your health insurance information. In the event your claim is denied or delayed, your claim will be filed with your group health insurance. If your injury becomes a legal matter and payment is further delayed you will be billed directly and responsible for payment of all unpaid balances.

Returned Check Fee / Collection Costs: You agree to pay a \$25.00 service charge on all return checks. You also acknowledge that you are fully responsible for the payment of all services provided. If your account is assigned to an attorney or collection agency for failure to pay, you will be responsible for the cost of collection, court costs and any reasonable attorney fees.

By signing below you affirm that you have read and understand our **Financial Policy** and that you agree to its contents.

Ernest Shultz
Signature of patient or responsible party

6/23/08
Date

ASSIGNMENT OF BENEFITS

In consideration of these medical services, I hereby assign, transfer and set over to Galesburg Orthopedic Services, Ltd. all my rights, title and interest to medical reimbursement benefits under my insurance policy(s). A photocopy of this Assignment is to be considered as valid as an original. This Assignment will remain in effect until revoked by me in writing.

Ernest Shultz
Signature of patient or responsible party

6/23/08
Date

CONSENT FOR RELEASE AND USE OF INFORMATION AND RECEIPT OF PRIVACY NOTICE

I, hereby give my consent to Galesburg Orthopedic Services, Ltd. to use or disclose, for the purpose of carrying out treatment, payment or health care operations, all information contained in the patient record of Ernest Shultz
(Patient's Name)

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician has reserved a right to change his or her privacy practices that are described in this Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

I understand that this consent is valid until it is revoked by me by giving written notice to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information.

Ernest Shultz
Signature of patient or responsible party

6/23/08
Date

201 South Grand Avenue East
Springfield, Illinois 62763-0001

Telephone (217) 785-0710
TDD (217) 785-5612

DATES:

TO: Participating Hospitals; Chief Executive Officers, Chief Financial Officers, and Patient Account Managers; and Physicians
RE: Medical Services Provided to IDOC Inmates.

Effective Dec. 17, 2005, hospital providers should direct bill HFS for certain hospital services provided to inmates at IDOC facilities. These services include all Categories of service 20, 22, 24 and 29. It is the intent of HFS and IDOC to allow hospital providers to submit bills in accordance with current billing practices as outlined in the hospital handbook. Until such time as system changes are in place we are requesting that hospital providers submit bills for services rendered to IDOC inmates via the hardcopy (UB-92) method outlined in the hospital handbook.

We are requesting that when a bill is prepared, the bottom portion of this document accompanies the bill to allow HFS staff to identify and handle these claims appropriately. In the event that an HFS RIN is not available at the time of billing, please submit the fully completed, hardcopy (UB-92) without the RIN and HFS will assist in assigning a correct RIN to the claim in order to process it. As soon as system changes are in place to electronically process IDOC claims, all providers will be notified and the hardcopy claim process will end. Hospital providers will then use their current system of billing.

It is the intent of HFS and IDOC to expedite payment for services rendered to IDOC inmates. It is the intent to cycle for payment once a month, all clean claims received during the month for IDOC inmates. This should allow for an average payment cycle of approximately 30 days.

Your patience and participation with this interim process is greatly appreciated.

Please mail your completed bills to (and direct any questions to):

Healthcare and Family Services
Attn: Don Jenkins
Bureau of Rate Development and Analysis
201 South Grand Ave, East, 2nd Fl.
Springfield, Illinois 62763-0001

PH# 217-785-0710

RETURN WHEN SUBMITTING BILL TO HFS FOR PAYMENT
(To be completed by IDOC prior to arrival).

Date of Service:

10-23-08

Inmate Name (As provided by IDOC Staff):

Shields, Ernest J BGD/KC

SSN (if known):

WIA



08/16/2008 10:00 AM
430, 1A / 008 5:53PM

License
Fadi (18) Village Hospital

PATIENT REFERENCE NO.

PAGE 2 OF 2

56-5047 P. 2

Number: 5254682
Name: PATIENT NUMBER 6
Ref/Dis: OFF / 208
Admit: 4/16/08
Dis: 4/16/08
Address: N/A
DOB: 2/13/71
Age: 37
Height: 170cm
Weight: 70kg

Ordering Dept: RNP
Order Rx/Dr: 4/16/08 17:00
Order Rx/Dr: 4/16/08
Start Rx/Dr: 4/16/08 17:00
End Rx/Dr: 4/16/08
Order Phys: PHYSICIANS NAME
Admit Phys: PHYSICIANS NAME
Primary Phys:
Jacket X

DISPENSING HOSPITAL
IV/001 ERN
LDR 1A
ER 2/07 SA

00042864

Last Exam Date:

Private weight lifting
Heart palp. Room.
Limited ROM joint.
Severe pain in joint.

200 kg weight lifting
SIXTH EXAM ROOM
WORN

MRI (L) shoulder - moderate tendinosis
or partial tear supraspinatus tendon
otherwise Ø

S. Cabral, MD

2008-07-07

Faxed & called
to ER 008
4/16/08

MS.C

Galesburg Cottage Hospital
695 North Kellogg Street
Galesburg, IL 61401

CONFIDENTIAL PATIENT

MRSA:

Advanced Directives: (Y/N) N

PATIENT DEMOGRAPHICS

Name: SHIELDS EARNEST D DOB: 02/19/1971 Age: 37 MR#: 000418894
Address: PO BOX 1327 SSN: 777-77-7777 Sex: M Race: B
GALESBURG IL 61401 Religion: N Marital Status: S

Home Phone: (309)343-4212 Employer: Work Phone: Occupation: INMATE B66161
Former Name:
Birth Place - State: IL
Parent/Spouse Name:
Parent/Spouse SSN:
Emergency Contact: HENRY HILL Home Phone: (309)343-4212 Work Phone: (000)
Emergency Contact: Home Phone: (000) Work Phone: (000)

GUARANTOR

Name: HENRY HILL DOB: Age: Relation: G8
Address: PO BOX 1327 SSN: Sex: M
GALESBURG IL 61401 County:
Employer:
Work Phone: Occupation: INMATE B66161
Home Phone: (309)343-4212

INSURANCE

Plan #: 415 2 Plan Name: WEKFORD HEALTH SOURCES Financial Class: G
Plan ID: INMATE B66161 Plan Address: PO BOX 15471 Verified Ins. Plans:
Group #: PITTSBURGH PA 15242
Group Name: OP Plan Phone: (412)937-8590 COB: Y
Subscriber Name: SHIELDS EARNEST D PT Rel: SELF DOB: 02/19/1971
Employer Name: Employ Status: INMATE B66 SSN:
Treatment #:

Plan #: 0 0 Plan Name: Plan Address: COB:
Plan ID: Plan Address: DOB:
Group #: Group Name: Plan Phone: Treatment #: SSN:
Subscriber Name: PT Rel: COB:
Employer Name: Employ Status: DOB:
Treatment #: SSN:

Plan #: 0 0 Plan Name: Plan Address: COB:
Plan ID: Plan Address: DOB:
Group #: Group Name: Plan Phone: Treatment #: SSN:
Subscriber Name: PT Rel: COB:
Employer Name: Employ Status: DOB:
Treatment #: SSN:

REGISTRATION

Admitting Physician: 817 BOMMIA SAMY VEERASIKKU MD
Attending Physician: 817 BOMMIA SAMY VEERASIKKU MD
Primary Care Physician: 0

Diagnosis 1: SHOULDER INJURY

Diagnosis 2:

Procedure:

Complaint:

Accident Onset Date:

Accident Place:

Comments: DCNDT

Med/Champus Imp. Mag:
Adm. Priority:

Adm. Source: 7

MSP Quest:
Pl. Accom Type:
Pl. Service EOP ABN:
SMN Status: Private Room Arrangement:
Valuables:
Envelope #:

Arrival Date: 06/16/08 15:00
Registrar: NLD

Last D/C Date: 06/16/08
Patient Number: 5290082

Patient Room:

Patient Unit or Station:



OS Shoulder Injury (4)

TIME SEEN: 30 on arrival ROOM: 8 EMS Arrival

HISTORIAN: patient spouse paramedics

HX / EXAM LIMITED BY:

HPI

chief complaint: injury to right/left shoulder arm neck

duration / occurred: just prior to arrival today yesterday	where: home neighbor's work school park street
severity of pain: mild moderate severe	worse / persistent since pain intermittent / lasting
context: fell direct blow dislocated while raising arm	<u>W. Night - Direct blow to shoulder and felt pain</u>
associated symptoms: tingling / numbness diaphoresis shortness of breath	
ROS neck pain blow to head chest pain head / neck injury other	

PAST HX negative R/L HANDED prior injury diabetes Type 1 Type 2 diet / oral / insulin

Medic- none / see nurses note

Allergies- NKDA / see nurses note

Nursing Assessment Reviewed Vital Signs Reviewed Tetanus Immun. UTD Y/S BP RR Temp

PHYSICAL EXAM

GENERAL APPEARANCE c-collar (PTA / In ED) / backboard no acute distress alert

SHOULDER normal inspection full ROM no dislocation

UPPER EXTREM. uninjured below shoulder

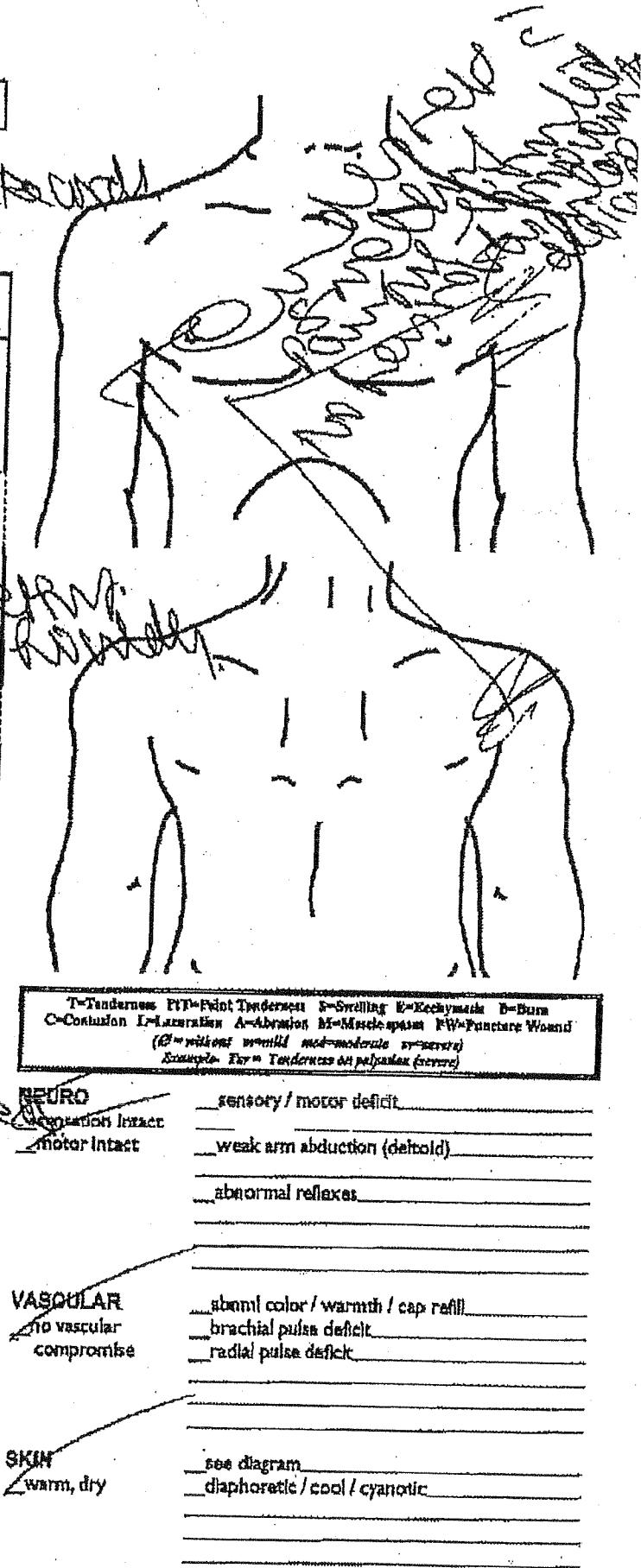
NEURO sensation intact motor intact sensory / motor deficit weak arm abduction (deltoid) abnormal reflexes

VASCULAR no vascular compromise abdominal color / warmth / cap refill brachial pulse deficit radial pulse deficit

SKIN warm, dry see diagram diaphoretic / cool / cyanotic

© 1996 - 2006 T-System, Inc. Circle or check affirmatives, backslash (\) negatives.

Galesburg Cottage Hospital 815 N. Kellogg Street, Galesburg, IL 61401 309-343-3131



SHIELDS ERNEST D
Patient #: 5290082 HSV: EOP
Adm date: 2008-08-16 Medical Rec#: 418804
Adm Dr.: DOMMIA SAMY VEERASIKKU MD
DOB: 1971-02-19 Age: 37 Sex: M

HEAD / ENT
oral inspection
pharynx nml

tenderness
swelling
ecchymosis

NECK / BACK
oral inspection
non-tender
painless ROM

tenderness
swelling
ecchymosis
vertebral point-tenderness

RESPIRATORY
chest non-tender
no resp. distress
breath sounds nml

tenderness
ecchymosis / abrasions
crepitus / subcutaneous emphysema
wheezes / rales / rhonchi

CVS
heart sounds nml
rate/beat & rhythm

tachycardia / bradycardia

ABDOMEN
non-tender
no organomegaly

tenderness
guarding

PROCEDURES

REDUCTION OF SHOULDER DISLOCATION

- IV sedation
 Traction / Counter Traction
 Kocher maneuver
 Weights (lbs)
 Scapular manipulation
 Other
 See Conscious Sedation Sheet

X-RAYS Interp. by me Reviewed by me Discussed w/ radiologist

L / L Shoulder Clavicle

normal / NAD
nml alignment
no fracture
nml soft tissue
shoulder dislocation (anter/poster)
AC joint separation 1° 2° 3°
fracture non-displaced displaced
clavicular Hill-Sachs humeral
transverse oblique comminuted angulated
impacted arm

ther. study:

See separate report

DST-REDUCTION X-RAY

nml (anatomic position)
reduced Hill-Sachs fix

CHECK POST-REDUCTION:

pt somnolent

SUNG

HER

✓ shoulder immobilizer / clavicle strap

PROGRESS

Time

unchanged

improved

re-examined

DISPOSITION: home admitted transferred

Time

CONDITION:

unchanged improved stable

Dictated Addendum

Template Complete

MD / GO

SHIELDS ERNEST O
Patient #: 5290062 HSV: EOP
Adm date: 2008-06-16 Medical Recd: 418694
Adm Dr.: BOHM/ASAMY VEERASIKKU MD
DOB: 1971-02-19 Age: 37 Sex: M

PATIENT NAME

O.P. NUMBER

DATE

FOLLOW UP INSTRUCTIONS

- Follow-up & Re-evaluation in _____ hours, _____ days, _____ weeks.
 Call for appointment.
 Appointment has been made for _____
PHYSICIAN _____
ADDRESS _____
PHONE _____
 OP Tests _____

- Call your MD's office in 72 hours for your final culture report.
 X-rays do not always show injury or disease, and fractures may not be revealed on the initial x-rays. If the problem persists or worsens, additional x-rays or tests may be required. If this occurs, you should contact your physician or return to the ER. Your initial x-ray reading is a preliminary report. The radiologist will make a final reading. You will be informed if there is any significant difference from the preliminary reading.
 For Workers' Compensation patients see company MD within 24 hours for follow-up.
The physician services in the Galesburg Cottage Hospital Emergency Department are provided by Advanced Emergency Specialists, an independent contractor. The physicians comprising this group are not agents or employees of Cottage Hospital. The evaluation and treatment you have received in the Emergency Department has been rendered on an emergency basis only, and is not intended to be a substitute for, nor an effort to provide complete medical care. Because it is impossible to recognize and treat all elements of an injury or illness in a single emergency visit, it is important that you follow-up with your physician or the referring physician for your safety. Follow the instructions outlined below. If your present condition persists or worsens please contact the physician listed below. If unable to contact this physician you may return to the Emergency Department at any time.

PROVISIONAL DIAGNOSIS

OTHER SPECIFIC INSTRUCTIONS

IT IS VERY IMPORTANT FOR YOU TO FOLLOW-UP AS DIRECTED, ESPECIALLY IF YOUR CONDITION PERSISTS, OR WORSENS, OR YOU DEVELOP NEW SYMPTOMS.

I HEREBY ACKNOWLEDGE RECEIPT OF AND UNDERSTAND THE PRINTED AND VERBAL INSTRUCTIONS.

SIGNATURE OF PATIENT OR RESPONSIBLE PERSON

SIGNATURE OF NURSE

Galesburg Cottage Hospital

309-343-8131

625 N. Kellogg St.

Galesburg, IL 61401

FOR

ADDRESS

Rx:

COMMIT IN BACK
 TO COPY
 NOT FOR
 PATIENT USE

Galesburg Cottage Hospital

625 N. Kellogg Street • Galesburg, IL 61401 • 309-343-8131

GENERAL INSTRUCTIONS

Persistent pain or disability for more than 72 hours are caution signs; notify your physician for further evaluation.

- Your eye has been patched. Please remove the patch in _____ hours. DO NOT DRIVE, as your ability to perceive depth will be impaired and your field of vision restricted.
 Ace/Splint
 Keep injured part at rest and elevated as much as possible.
 Ice intermittently to injured area for 24 hours. (On for 20 minutes then off for 20 minutes, etc.) Place cloth between ice bag to protect skin.
 Use heat.
 No weight bearing until okayed by your own physician, use crutches as directed.

MEDICATION INSTRUCTIONS

- Medications per reconciliation process.
 Due to medication you have been given in the emergency department, your alertness may be impaired and you may be drowsy. Do not drive, operate potentially dangerous machinery, or climb heights for 8 hours.
 Ibuprofen (Motrin, Advil) Adults: _____ milligrams, # _____ every _____ hours. Please stop ibuprofen if you should develop abdominal pain, blood in your stools or black stools. DO NOT USE IF ALLERGIC.
 Acetaminophen (Tylenol) Adults: _____ milligrams, # _____ every _____ hours. DO NOT USE IF ALLERGIC.

WOUND CARE INSTRUCTIONS

Follow-up with your own MD within 1 to 2 days for wound check. Call for appointment.
 Keep dressing clean and dry.
 Observe for signs of possible infection which include: redness, swelling, heat, red streaks, pus and/or drainage, increased pain, unexplained fever. CONTACT YOUR DOCTOR IMMEDIATELY IF THESE OCCUR.
 Arrange for suture removal in _____ days.

SPECIAL CARE INSTRUCTIONS

- Drink lots of cool fluids, water and juices etc. # Ounces _____ Per _____
- Take temperature every 2 - 4 hours.
- Extra rest.
- Call physician immediately if seizures or convulsions occur or if a rash develops.

DISCHARGE INFORMATION

- | | | |
|--|---|--|
| <input type="checkbox"/> Cold/flu, sore throat, cough | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Other Media Sheet |
| <input type="checkbox"/> Orthopedic injury care | <input type="checkbox"/> Back pain | <input type="checkbox"/> Animal Bite Sheet |
| <input type="checkbox"/> STD Instructions | <input type="checkbox"/> Head/Brain | <input type="checkbox"/> Immunization Card Given |
| <input type="checkbox"/> Burn Care | <input type="checkbox"/> Heat and Cold emergencies | |
| <input type="checkbox"/> Respiratory care, croup, asthma | <input type="checkbox"/> Vomiting/diarrhea in adults | |
| <input type="checkbox"/> Fever Care Instructions | <input type="checkbox"/> Urinary tract infection | |
| <input type="checkbox"/> Head Injury Sheet | <input type="checkbox"/> Bites | |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> General pediatric Instructions | |
| <input type="checkbox"/> Post Nosebleed Information | <input type="checkbox"/> Fever/Med Sheet | |

Form # 600-0170 (Rev. 3/00)

Galesburg Cottage Hospital

309-343-8131

625 N. Kellogg St.
Galesburg, IL 61401

FOR

DATE

The above was seen, treated, and released from our Emergency Department. I recommend:

- Release from usual/all employment responsibilities for _____ days.
 Release from participation in school classes/physical education / athletics for _____ days.
 Immediate return to work/school.
 Restrictions: _____

COPY
 NOT FOR
 PATIENT USE

M.D.

EMERGENCY ROOM
 May Not Substitute
 May Be Required

DEA NO.

D.O.

D.N.R.

ABSTAIN/SAFETY